| MEDICAL RECORD | Request for Performance of Procedures:<br>Fluorescein Angiography |
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**EXPLANATION OF THE PROCEDURE**: Angiography is a procedure where a rapid series of photographs will be taken to study the blood flow in two parts of your eye – the choroid and the retina. To make it easier for us to see the blood flow in your eye, we will inject a dye called Fluorescein. The dye is usually injected into a vein in the arm, forearm, or hand. Since the Fluorescein dye is a very bright yellow, your skin may appear orange for a few hours before the orange color disappears. The dye leaving your body will cause your urine to be a bright yellow for 24-36 hours.

**POSSIBLE RISKS AND COMPLICATIONS**: A few patients who are given the dye have a reaction to it. The types of reactions that have been reported are nausea and/or vomiting (5%), hives and/or itching (1%), or cardiac event/stroke/anaphylaxis (<1%). All adverse reactions will be treated with proper medication.
It is possible that the fluorescein dye will leak out of a blood vessel into areas under the skin. If this happens, it is painful. Our staff will use their best efforts to prevent this leakage from happening.

**ACKNOWLEDGMENTS**:
1. I understand that photographs will be taken during this procedure. I consent to the use of these photographs for training and scientific purposes so long as neither the pictures nor any written words accompanying them identify who I am.
2. I request that the angiography procedure be done. I also agree that while you are doing the angiography, you may do additional services that the professional staff of the Warren Grant Magnuson Clinical Center judge to be needed or useful.
3. I understand that no guarantees of any kind regarding this procedure have been made to me.
4. I understand this procedure is to be performed by, or under the direction of, Dr._____.

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1. **Physician**: I have counseled this patient as to the nature of the proposed procedure, the risks involved, and the expected results, as described above.

_____ _____
(Signature of Physician) (Date)

2. **Patient**: I understand the nature of the proposed procedure, the risks involved, and the expected results, as described above, and hereby request that the procedure be performed.

_____ _____
(Signature of Patient) (Date)

3. **Sponsor or Guardian**: I, _____sponsor/guardian of _____ understand the nature of the proposed procedure, the risks involved, and the expected results, as described above, and hereby request that such procedures be performed.

_____ _____
(Signature of Sponsor/Guardian) (Date)

4. **Witness**

_____ _____
(Signature of Witness excluding members of operating team) (Date)